NATIONAL HEALTH SERVICE CORPS EDUCATIONAL PROGRAM FOR CLINICAL AND COMMUNITY ISSUES IN PRIMARY CARE

CHILD ABUSE, NEGLECT, AND DOMESTIC VIOLENCE MODULE

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SUBTOPIC 1

CHILD SEXUAL ABUSE

TIMELINE (50 minutes)

5 min	Introduction/Ice Breaker
5 min	Review of Objectives/Format
5 min	Overview
30 min	Review of Case/Questions
5 min	Additional Questions and Answers

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners, nurse practitioner trainees, nurse midwives, physician assistants and physician assistant trainees.

At the end of this discussion, participants should be able to:

1. Identify five major family risk factors for sexual abuse of children.
2. Understand the relationship of sequelae of sexual abuse to the symptoms of post-traumatic stress disorder in children.
3. Know the most specific symptom of child sexual abuse, which is sexual acting out.
4. Understand the importance of non-directive interviewing when talking with children about possible sexual abuse.
5. Understand that many children who have been sexually abused have normal physical examinations.
6. Understand the health care practitioner's responsibility to report suspected child abuse to civil authorities.

SECTION 2 OVERVIEW

Sexual abuse is a common experience for children. When adults are surveyed about sexual experiences in childhood, one in four women and one in 10 men report being abused during their childhood. Sexual abuse is widespread in all socioeconomic and racial groups. No subgroup has been identified where it is clearly absent or rare. Primary care practitioners are often the first to be consulted when a family suspects sexual abuse.

Studies of the epidemiology of sexual abuse have identified factors associated with the risk of abuse, including:

- Growing up in families with unrelated male caretakers
- Growing up in socially isolated families
- Having an absent or unavailable mother
- Drug and/or alcohol abuse by parents
- Growing up in homes where other family members have a history of sexual abuse
- Strong need on the part of the child for attention
- Disabilities requiring residential placement or direct physical management

When children are sexually abused, they may be asymptomatic. Often, however, they will show nonspecific signs of stress. These can include regressive behaviors, anxiety, depression, withdrawal, school failure, fear of adults, sleep disorders, psychosomatic pain, hostility, or aggressive behaviors. Factors associated with more severe distress in sexually abused children include the following:

- Abuse involving penetration of the mouth, anus, or vagina
- Abuse involving the use of force
- More frequent abuse
- Abuse of longer duration

Younger children who have been sexually abused are more likely to act out sexually. While all children masturbate and show an interest in their own anatomy and the anatomy of others, sexually abused children will often display explicit or aggressive sexual behaviors. These children do not have the intellectual or emotional maturity to understand the sexual behaviors they learn from the abuse.

Older children and teenagers who have been sexually abused will sometimes become sexually promiscuous and/or use drugs or alcohol to deal with their emotional problems. Most teenage runaways come from physically or sexually abusive homes. They are also likely to experience shame, guilt and a lack of self esteem.

Many of the symptoms of emotional distress in sexually abused children are similar to the symptoms of postraumatic stress disorder (PTSD). Symptoms of PTSD include depression, obsessive thoughts about the traumatic experience, flash-backs to the experience, and an

exaggerated startle response. Children who have experienced major trauma often act and respond similarly to sexually abused children, except for the sexual acting out and sexual behavior disorders.

Physical signs of sexual abuse sometimes include enuresis, encopresis, and genital and/or anal pain, bleeding, or discharge. However, many children will not manifest these signs, depending on the nature or extent of the abuse.

When interviewing children about possible abuse experiences, it is important to be non-directive and to ask non-leading questions such as, "Tell me why your mom brought you to see me today," or "What makes you feel sad?," or "Has anybody ever touched you in a way that made you feel uncomfortable or upset? Tell me about it."

Questions that suggest an answer are not helpful, and may confuse the child and lead to false conclusions, particularly when very young children are being interviewed. Many communities have specially trained social workers, psychologists, nurses, or physicians available to interview children when abuse is suspected.

Sexually abused children often have normal physical examinations. The reasons include the following:

- Many abused children do not disclose their abuse for weeks, months, or even years after the abuse. Complete and dramatic healing of anal or genital injuries can occur.
- As children develop and mature, their genitals undergo major changes. This, too, can hide signs of previous abuse.
- Many children are abused in ways that do not leave injury, including fellatio, cunnilingus, fondling, or having adults expose themselves.

Sometimes, children who have been sexually abused have genital/anal tears or scars. Practitioners who care for children should have a good knowledge of normal genital and anal anatomy of children in various stages of development so they can recognize abnormal findings.

Once a child discloses abuse, it is important for that child to be supported and believed. A hostile or disbelieving response from an adult may cause the child to recant a true story and withdraw from potential help.

Families are in terrible turmoil when sexual abuse of a child is disclosed; they need emotional support and guidance. When the person accused of the abuse is part of the family, it may be difficult for other family members to believe the child's story. The family may be even more resistant to believing the child if the child's physical examination is normal. A health care practitioner can help convince a family that a normal physical examination does not rule out sexual abuse.

All 50 states in the U.S. have mandatory child abuse reporting laws. When child abuse is suspected, all physicians, nurses, physician assistants, allied health professionals, and mental health

professionals are required to report to the local social services agency charged with protecting children.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

Shawna Jones is a three–year–old girl brought to the practice by her mother. Mrs. Jones has recently separated from her husband of five years. She says her marriage was "stormy" and she is afraid of her husband because of violent outbursts. Shawna has been wetting the bed after being previously night trained and also masturbates frequently when she watches television. Last week when Shawna's father came to pick her up for visitation, Shawna screamed and kicked and did not want to go with him. Mrs. Jones wants her checked for sexual abuse.

Mrs. Jones has been to a lawyer and has decided to seek a divorce. She is concerned about her husband's having access to Shawna and is asking for full custody without visitation by the father. Mr. Jones has made it very clear that he will fight for joint custody. A protracted legal battle is likely.

The health practitioner asks Shawna, "Does your Dad ever touch you in your private places?" She answers, "Yes." Her physical examination is entirely normal, including a careful inspection of the genitals and anus.

1. What factors in Shawna's history suggest that she might have been sexually abused?

2. Do children lie about sexual abuse?

3. What family characteristics are more common in cases of sexual abuse?

4. What do you think of the practitioner's interview of Shawna? Could Shawna's response be misinterpreted? What would have been a better way of approaching Shawna about the question of possible abuse?

5. Does the fact that Shawna's exam is normal rule out sexual abuse?

6. If sexual abuse is suspected, should Shawna be cultured for sexually transmitted diseases?

7. Would you report this case to social services as possible child abuse?

SECTION 4 SUGGESTED ANSWERS

1. *What factors in Shawna's history suggest that she might have been sexually abused?*

    - Her father may have a problem with anger management and/or impulse control. The change in bladder training is concerning.
    - Use Handout/Overhead 1 entitled "Symptoms and Signs of Sexual Abuse in Children." Point out that it is very difficult to make the diagnosis of abuse in young children by parent's history alone because all of the symptoms listed can also be seen in children who have experienced stress or trauma, such as the divorce of parents and parents fighting in front of the child.
    - It is difficult to include masturbation as a symptom of sexual acting out, since most children masturbate to some degree, and parents often overreact to it.

2. *Do children lie about sexual abuse?*

    Studies of false allegations of abuse have shown that children rarely lie about it. Jones, et al., showed that 1.5 percent of sexual abuse cases reported to social services involved false allegations by children. Faller, et al., found a much higher percentage of false allegations in cases involving custody disputes between divorcing parents (15 percent), but even then, children were not often noted to lie about abuse. In this case, Shawna has not made any spontaneous outcry about abuse. In cases where parents are in conflict, the parent's interpretation of the child's behavior must be interpreted carefully. When determining whether or not abuse occurred, look for a spontaneous, consistent, developmentally appropriate report by a child who has not been pressured to report abuse by an angry parent.

3. *What family characteristics are more common in cases of sexual abuse?*

    Use Handout/Overhead 2 entitled, "Risk Factors for Sexual Abuse." Point out that many children who are sexually abused will come from families without known risk factors.

4. *What do you think of the practitioner's interview of Shawna? Could Shawna's response be misinterpreted? What would have been a better way of approaching Shawna about the question of possible abuse?*

    Before asking a child about possible abuse, the practitioner needs to find out the child's vocabulary related to his or her body. Questions asked should be understandable by the child given his or her age, vocabulary, and developmental level. Shawna might have called her genitals something other than "private places." Her answer also could have meant her Dad washed her or helped her wipe after going to the bathroom.

Discuss the need for non-directive interviews that let children describe things in their own words. The health practitioner in this case made two mistakes when asking the child a question about abuse–the question was ambiguous and the question was leading. Ask the audience what questions could have been asked that would have been more effective.

The videotape, "Child Sexual Abuse: Interviewing the Young Child," contains several good examples of interview questions. However, anatomically correct dolls should not be used for interviewing unless the practitioner has had extensive training in their use.

5. *Does the fact that Shawna's exam is normal rule out sexual abuse?*

No. (See Section 2, "Overview," for explanation.)

6. *If sexual abuse is suspected, should Shawna be cultured for sexually transmitted diseases?*

Children can contract all of the sexually transmitted diseases (STDs) found in adults. The Centers for Disease Control and Prevention (CDC) makes recommendations about STD testing in suspected sexual abuse cases. Generally, if the child has vaginal, anal, or penile discharge, the yield from STD testing is low. Very little epidemiological data exist on STD pathogens in children. Most experts recommend STD testing if the child is symptomatic, or if the offender is known to have STDs or is at "high risk" of having STDs.

7. *Would you report this case to social services as possible child abuse?*

See Handout/Overhead 3 entitled "Guidelines for Making the Decision to Report Sexual Abuse of Children."

SECTION 5 SUGGESTED READING

1. Briere J, Berliner L, Bulkley JA, Jenny C, and Reid T: *The APSAC Handbook on Child Maltreatment.* Sage Publications, Thousand Oaks, CA, 1996.
   This handbook reviews the entire spectrum of child abuse and neglect, and includes chapters on medical aspects of diagnosis and treatment.

2. Hymel KP, and Jenny C. Child sexual abuse. *Pediatr in Rev* 17:236–250, 1996.
   This article reviews the entire medical work-up of sexually abused children, from the interview to the creation of the medical record.

3. Bays J, and Chadwick D. Medical diagnosis of sexually abused children. *Child Abuse and Neglect* 1993;91–110.
   Bays and Chadwick have written a very thorough review on the interpretation of physical findings in sexually abused children.

4. Centers for Disease Control and Prevention. 1998 Guidelines for the treatment of sexually transmitted diseases. *MMWR* 1998; 47:1–111.
   The CDC's guidelines include recommendations for when to test children who are suspected to have been sexually abused for sexually transmitted diseases.

5. American Medical Student Association, St. Louis University Medical School chapter. *Child Abuse Prevention Project, Manual and Guidelines, Version 3,* 1992.
   This manual helps health professions students organize a child sexual abuse prevention project in their communities. It explains how to develop and implement community outreach and education activities for children in grades kindergarten through fifth grade. In addition, the manual helps health professionals understand different approaches and resources for handling child abuse issues.

   Available through AMSA's Resource Center, 1902 Association Drive, Reston, VA 22091-4325, 703-620-6600, ext. 217.

SECTION 6 AUDIO-VISUAL RESOURCES

1. **Cases of Concern: The Examination and Diagnosis of Child Sexual Abuse (55 min).** A training video intended for medical professionals. Covers the medical examination of sexual abuse victims, medical and behavioral history taking, sexually transmitted diseases, and medical-legal testimony. $150.

   Author/Developer: Harborview Sexual Assault Center, Seattle, Washington.

   Contact: Christine Feldt, Harborview Sexual Assault Center, 325 Ninth Avenue, ZA-07, Seattle, WA 98104.
   Telephone: 206-223-3047.

2. **Child Sexual Abuse: Interviewing the Young Child (40 min).** This video describes the stages and components of forensic interviews of pre-school aged children. $175.

   Contact: The Center for Child Protection, Children's Hospital and Health Center, 8001 Frost Street, San Diego, CA 92123.
   Telephone: 619-576-5803.

3. **The Visual Diagnosis of Child Sexual Abuse.** The American Academy of Pediatrics' Section on Child Abuse and Neglect has published a teaching slide collection about physical findings in child sexual abuse. The slide set covers normal anatomy, genital and anal pathology, as well as physical findings resulting from abuse. The slide set includes 164 slides and a teaching manual describing each slide in detail. $150.

   Author/Developer: The American Academy of Pediatrics, Elk Grove Village, Illinois, 1998.

   Contact: American Academy of Pediatrics Publications:
   Telephone: 800-433-9016.

SECTION 7 HANDOUTS/OVERHEADS (ATTACHED)

Signs and Symptoms of Sexual Abuse in Children

NON-SPECIFIC SIGNS

Regression
Anxiety
Social withdrawal
School failure
Fears and phobias
Sleep disorders
Psychosomatic pain
Hostility
Aggression
Promiscuity
Alcohol/drug abuse
Running away
Lack of self esteem

SIGNS OF PTSD

Obsessive thoughts
Depression
"Flashbacks"
Exaggerated startle response

SPECIFIC SIGNS

Sexual acting out

Risk Factors for Sexual Abuse

Unrelated male caretakers

Socially isolated families

Absent or unavailable mother

Drug/alcohol abuse in home

History of sexual abuse in other family members

Strong need on the part of the child for attention

Disabilities requiring residential placement or direct physical management

HANDOUT/OVERHEAD 2

Guidelines for Deciding to Report Sexual Abuse of Children

DATA AVAILABLE			RESPONSE TO DATA	
History	**Physical exam**	**Laboratory**	**Concern About Sexual Abuse**	**Action**
None	Normal exam	None	None	None
Behavioral changes	Normal exam	None	Low (worry)	+/- Report Close followup (Possible mental health referral)
None	Nonspecific findings	None	Low (worry)	+/- Report Close followup
Nonspecific history by child or history by parent only	Nonspecific findings	None	Possible (suspect)	+/- Report Close followup
None	Specific findings	None	Probable	Report
Clear statement	Normal exam	None	Probable	Report
Clear statement	Specific findings	None	Probable	Report
None	Normal exam, nonspecific findings or specific findings	Positive for gonorrhea or syphilis; presence of semen, sperm or acid phosphatase	Definite	Report
Behavioral change	Nonspecific changes	Other STDs	Probable	Report

HANDOUT/OVERHEAD 3

SUBTOPIC 2

CHILD PHYSICAL ABUSE

TIMELINE (45 minutes)

5 min	Introduction/Ice Breaker
5 min	Review of Objectives/Format
5 min	Overview
25 min	Review of Case/Questions
5 min	Additional Questions and Answers

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners, nurse practitioner trainees, nurse midwives, physician assistants and physician assistant trainees.

At the end of this discussion, participants should understand:

1. Psychosocial risk factors contributing to child maltreatment.

2. The five major factors of the patient's history to consider in order to distinguish accidental injuries from nonaccidental trauma (child abuse).

3. Common "triggers" of child physical abuse incidents.

4. Common characteristics of abusive burns.

5. The indications for skeletal surveys when nonaccidental trauma is suspected.

6. The health care practitioner's responsibility to report suspected child abuse to civil authorities.

SECTION 2 OVERVIEW

In 1996, child protective service agencies investigated more than 2 million reports of alleged maltreatment to children, or 44 reports per 1,000 American children under age 18. Two thirds of these reports were substantiated, involving about 1 million children, an 18% increase since 1990. An estimated 1,070 children died from abuse in 1996. Seventy-six percent of these were children under four years of age. Child abuse is a problem likely to be encountered by primary care health practitioners, but it often goes unrecognized.

Although child abuse occurs in all social and economic strata of society, several epidemiological factors have been identified in studies of the incidence and prevalence of abuse:

- Family stress, including domestic violence, social isolation, poverty, and unemployment, increase the likelihood of physical child abuse.
- Mothers are most likely to be perpetrators of child abuse. On the other hand, most child deaths occur at the hands of male caretakers, particularly mothers' boyfriends and fathers of children.
- Male children are more often physically abused than female children.
- Prematurely born children and children with low birth weight and/or low apgar scores are at increased risk for child abuse. This may represent a disorder of parental/child attachment caused by problems with early bonding.
- Family stress, economic stress, and unemployment are risk factors for physical abuse.
- Parents who were abused as children are at increased risk for abusing their own children.

Infants and toddlers are more at risk for abusive head trauma, burns and fractures, while older children are more likely to sustain bruising, abrasions, and pattern marks from beatings.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

Jason Martin is a 22–month–old boy who presents to the emergency room with burns to both hands (See Slide 1 depicting Jason's burns). His mother's boyfriend Mike was baby-sitting him. He fed Jason, then took him to the bathroom to wash Jason's hands. He left Jason on the counter next to the sink when answering the phone, and returned to find Jason "playing in the sink." Mike noticed Jason's hands were red so he put petroleum jelly on them and put him down for a nap. Ms. Martin arrived home to find Jason in bed crying. She immediately brought him to the hospital.

On examination, Jason has partial thickness and full thickness ("second and third degree") burns to both hands.

1. What factors in the history would make you suspicious that this injury may be nonaccidental?

2. Can you imagine how this injury might have happened to Jason? What would you hypothesize was happening at home when Jason received the burns?

3. What about these burns would raise your index of suspicion that this was not an accidental injury?

4. What other medical workup would you want to get on this child to rule out abusive injuries?

5. If further workup revealed other injuries, how would that affect your assessment of these burns?

6. How would you feel about working with Mike and Jason's mother? How do you handle feelings of anger or disgust when dealing with abusive parents or with parents who fail to protect their children? How will these feelings affect your ability to recognize and treat child abuse?

7. Have you ever made a report of child abuse to a social services agency? Do you know how to go about doing so?

SECTION 4 SUGGESTED ANSWERS

1. *What factors in the history would make you suspicious that this injury may be nonaccidental?*

   Several factors should be considered when evaluating cases where the injury could be accidental or nonaccidental (See Handout/Overhead 1 entitled, "Characteristics of Child Abuse Injuries").

   - Is the injury sustained consistent with the history given? Often in nonaccidental trauma, caretakers will report that major injuries were caused by minor events. For example, a child with serious or fatal nonaccidental head injury will present with the history of a trivial fall. In this case, there was no history given by the mother's boyfriend to account for the severity of Jason's injuries.

   - Was there a delay in seeking care? When caretakers cause an injury to a child, they may be afraid to seek care until the child becomes critically ill. Jason's caretaker did not bring him in immediately for care.

   - Has the history of the injury changed over time? Have different observers given different histories? Sometimes caretakers will change the medical history when they begin to sense the medical personnel are skeptical of the history given.

   - Is the affect of the caretaker appropriate? Sometimes, an abusive caretaker will seem unconcerned even if the child is seriously injured.

   - Are there unrelated injuries to other parts of the body or unexplained injuries of different ages?

2. *Can you imagine how this injury might have happened to Jason? What would you hypothesize was happening at home when Jason received the burns?*

   Certain "trigger" events often seem to precipitate child abuse injuries, including severe or prolonged crying and struggles around feeding or toilet use. In addition, parental strife and fighting may spill over into violent acts against children. In this case, one could imagine Jason made a big mess at meal time and Mike became angry and lost control.

3. *What about these burns would raise your index of suspicion that this was not an accidental injury?*

   Studies from emergency rooms have reported that overall, four to eight percent of burns in children are caused by child abuse, while 28% of hot water immersion burns are

abusive. Nonaccidental burns are usually distinguishable from accidental burns by burn patterns and historical characteristics. Abusive burns are more likely to be (see Handout/Overhead 2 entitled "Common Characteristics of Nonaccidental Burns"):

- Stocking/glove distribution on the body
- Immersion burns in hot liquids
- Burns without splash marks indicating a struggle
- Reported as "unwitnessed" or reported as caused by a sibling
- Burns that require more advanced motor skills to accomplish than the child possesses

Accidental burns in children are most often "cascading" burns from hot liquids spilling from a high surface. A typical history is that the child pulls a bowl or cup of hot liquid from a table. These burns have decreasing severity toward the lower trunk and legs, and often show splash marks.

In Jason's case, it is unlikely that a child playing in water would have very clear "water marks" on his hands and no splash marks.

4. *What other medical workup would you want to get on this child to rule out abusive injuries?*

Jason's physician ordered a skeletal survey. (See Slide 2 depicting Jason's skeletal survey.) The skeletal survey revealed old rib fractures and a metaphyseal fracture of the distal end of the right tibia. (See Slide 3.)

Fractures in young children are often occult. Certain types of fractures are commonly associated with child abuse, including posterior rib fractures, complex or diastatic skull fractures, and metaphyseal fractures of the long bones. In abused children under two years of age, a skeletal survey (radiographs of all the bones in the body) will often reveal asymptomatic fractures or fractures in different stages of healing. The American Academy of Pediatrics recommends a skeletal survey be done in all cases of suspected child abuse when the child is less than two years of age.

5. *If further workup revealed other injuries, how would that affect your assessment of these burns?*

The presence of serious injuries to more than one part or the body or to more that one organ system definitely raises the likelihood that the child has been abused. In addition, injuries of different ages indicate a pattern of ongoing abuse. In this case, the old fractures and the new burns mean this child is in serious danger in his current home environment.

6. *How would you feel about working with Mike and Jason's mother? How do you handle feelings of anger or disgust when dealing with abusive parents or with parents who fail to protect their children? How will these feelings affect your ability to recognize and treat child abuse?*

   Anger is a common but unproductive response to parents when issues of abuse or neglect surface. One of the roles of the health care practitioner is to continue to provide support and information to the parents while social services and police agencies serve as investigators of the complaint. On the other hand, the parents need to know that the medical record is available to police and social services. It is a difficult "balancing act" to try to maintain a relationship with the suspected abusers while also fulfilling one's legal obligations to the child protection system. Protecting the child is the physician's first concern.

7. *Have you ever made a report of child abuse to a social services agency? Do you know how to go about doing so?*

   All 50 states have mandatory child abuse reporting laws. When child abuse is suspected, all physicians, nurses, physician assistants, allied health professionals, and mental health professionals are required to report to the local social service agency charged with protecting children. In addition, medical practitioners are protected from liability ensuing from reporting suspected abuse, as long as the report is made in good faith.

SECTION 5 SUGGESTED READING

1. American Academy of Pediatrics Section on Child Abuse and Neglect. *A Guide to References and Resources in Child Abuse and Neglect.*
   This book reviews all of the major literature on medical aspects of child abuse published in the last 10 years. The references are summarized and critiqued.

2. Briere J, Berlinger L, Buckley JA, Jenny C, Reid T, eds. *The APSAC Handbook on Child Maltreatment.* Sage Publications, Thousand Oaks, California, 1996.
   The American Professional Society on the Abuse of Children published this book that covers the epidemiological, social, psychological, and medical aspects of the problem of child abuse.

3. Kleinman PK. *Diagnostic Imaging of Child Abuse*. Williams and Wilkins, Baltimore, MD, 1998.
   A very thorough text on radiological findings in child abuse, including the neuroradiology of abusive head trauma.

4. Purdue GF, Hunt JL, Prescott PR. Child abuse by burning. *J of Trauma* 28(3): 221–224, 1988.
   An excellent review of characteristics of burns associated with abuse.

SECTION 6 AUDIO-VISUAL RESOURCES

1. **The Visual Diagnosis of Child Abuse.** A 35mm slide set with accompanying audiotape and text illustrating common patterns of injury seen in abused children. $150.

   Author/Developer: Carole Jenny, MD and Thomas C. Hays, DO. Published by the American Academy of Pediatrics, 1995

   Contact: American Academy of Pediatrics, 800-433-7880

SECTION 7 HANDOUTS/OVERHEADS/SLIDES (ATTACHED)

SLIDE #1: Jason's burns ("Glove burns")

Characteristics of Child Abuse Injuries

Injury unexplained by history given

Delay in seeking care

Changing, evolving or inconsistent history

Inappropriate affect of caretaker

Unrelated injuries/injuries of different ages

HANDOUT/OVERHEAD 1

Common Characteristics of Nonaccidental Burns

Stocking/glove distribution

Immersion burns

Burns without splash marks

Unwitnessed burns

Burns requiring advanced motor skills on part of child

HANDOUT/OVERHEAD 2

SLIDE #2
(posterior rib fractures in different stages of healing)

SLIDE #3
(metaphyseal fractures of the distal tibia

SUBTOPIC 3

ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

TIMELINE (45 minutes)

5 min	Introduction/Ice Breaker
5 min	Review of Objectives/Format
5 min	Overview
25 min	Review of Case/Questions
5 min	Additional Questions and Answers

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners, nurse practitioner trainees, nurse midwives, physician assistants and physician assistant trainees.

At the end of this discussion, participants should understand:

1. The common psychological sequelae of adults who have been sexually abused as children.
2. The common physical sequelae of adults who have been sexually abused as children.
3. The characteristics of childhood sexual abuse that cause trauma for adult survivors.
4. How to approach the subject of possible sexual abuse when caring for adults in a primary care setting.

SECTION 2 OVERVIEW

Many emotional problems in adults have been found to be associated with a history of sexual abuse in their childhood, including depression, substance abuse, borderline personality disorder, criminal behavior, posttraumatic stress disorder (PTSD), and eating disorders.

Other problems such as low self esteem, anxiety disorders, sexual dysfunction, and psychosomatic illness are more common in adult survivors. Sexual victimization also has been shown to be a risk factor for contracting AIDS in adult women.

Abuse survivors have been found to utilize more inpatient and outpatient health services than those without a history of abuse. Thus, health care providers are likely to see adult survivors of sexual abuse in their practices. Recognizing the symptoms of childhood stress in adults can be helpful in managing patients with physical and psychosomatic complaints.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

Marilyn Abbott is a 30–year–old, married, nulliparous woman who presents for the treatment of chronic pelvic pain. She had had a laparoscopy and extensive gynecological workup done the previous year, which revealed no organic disease. Her menses are normal. She would like to become pregnant but finds the pelvic pain interferes with her ability to participate in sexual intercourse.

She has been treated for intermittent depression and currently is on antidepressants but has never been in psychotherapy. When asked about sexual abuse as a child, she tells the physician that she had been molested by her grandfather for many years, "but it's no big deal." On review of systems, she notes that she has had a past history of spastic colitis "controlled with diet" and feels tired a great deal of the time.

1. Given Ms. Abbott's presentation, how significant do you think her history of sexual abuse is in contributing to her symptoms?

2. She displays many of the psychological sequelae of abuse. What are they?

3. Chronic pelvic pain has been found to be much more prevalent in adult survivors of sexual abuse than in controls. What are the possible psychodynamic mechanisms involved in this dysfunctional adaptation to past trauma?

4. Why do you think the sexual abuse of children causes such profound long-term emotional sequelae in adulthood?

5. If Ms. Abbott refuses to go into psychotherapy, do you think she will ever recover from her chronic pelvic pain? Might she substitute another somatic symptom over time?

6. How can a primary care practitioner broach the subject of childhood trauma with an adult patient without being intrusive or disrespectful?

SECTION 4 SUGGESTED ANSWERS

1. *Given Ms. Abbott's presentation, how significant do you think her history of sexual abuse is in contributing to her symptoms?*

   There is no right answer to this question. The question can be used to generate discussion about the case and the participants' views.

2. *She displays many of the psychological sequelae of abuse. What are they?*

   Among the emotional reactions and self-perceptions experienced by adults molested as children, depression is the most common. Anxiety attacks, nightmares, and sleep disturbances are also common. Many adult survivors continue to feel stigmatized and isolated and have difficulty with self-esteem. Sexual dysfunction is reported by 40 to 90 percent of adult survivors in various clinical studies.

3. *Chronic pelvic pain has been found to be much more prevalent in adult survivors of sexual abuse than in controls. What are the possible psychodynamic mechanisms involved in this dysfunctional adaptation to past trauma?*

   Edward Walker, et al., (1988) suggest that chronic pelvic pain is "a metaphorical way of describing chronic psychological pain and may act as a defense or coping mechanism to protect against painful, emotion-laden memories."

4. *Why do you think the sexual abuse of children causes such profound long-term emotional sequelae in adulthood?*

   Finkelhor, et al., (1986) describe what he calls "four traumagenic dynamics" which are trauma-causing factors inherent in sexual abuse which leave lasting emotional scars. These are:

   - Traumatic sexualization—a process where a child's sexuality is shaped in developmentally inappropriate ways
   - Betrayal of the child's trust by someone the child loves and depends on
   - Powerlessness inherent in an unbalanced relationship
   - Stigmatization—where guilt and shame become incorporated into the child's self-image

5. *If Ms. Abbott refuses to go into psychotherapy, do you think she will ever recover from her chronic pelvic pain? Might she substitute another somatic symptom over time?*

There is no specific answer to this question. No long-term follow-up studies have been conducted to date. The question can be used to generate discussion about the participants' viewpoints.

6. *How can a primary care practitioner broach the subject of childhood trauma with an adult patient without being intrusive or disrespectful?*

The best way to bring up sexual abuse is by being honest and straightforward with the patient. Some physicians find it helpful to include questions about physical or sexual abuse in childhood during the first office visit or as part of routine physical examinations. Even if the patient does not feel comfortable discussing the topic, at least the physician sets the "ground rule" that "it is okay to discuss uncomfortable or unpleasant topics in this office." This may encourage the patient to bring up the topic at a later date.

A.L. Friedman and colleagues published an interesting study about asking patients about abuse in a general internal medicine clinic. They found that 78% of patients thought it was a good idea for physicians to ask about their sexual and physical abuse histories. Ninety percent of physicians in the same clinic agreed with that view. The patients were asked whether or not they were asked by doctors in the clinic about childhood trauma. Only 7% said they had been asked about this by their doctors. The authors concluded that overall, patients don't mind being asked about their abuse experiences. However, most doctors never asked these questions, in spite of the fact they thought it would be helpful.

Sometimes the topic can be introduced by asking general questions, such as, "What was your childhood like?" "How would you like your children's lives to be different from yours?" "Do you ever feel that experiences from your childhood continue to make things difficult for you today?"

SECTION 5 SUGGESTED READING

1. Finkelhor D. *A Sourcebook on Child Sexual Abuse*. Sage Publications, Beverly Hills, CA, 1986.
   A textbook summarizing research on the epidemiology, causes, and effects of child sexual abuse.

2. Briere JN. *Child Sexual Abuse Trauma. Theory and Treatment of the Lasting Effects.* Sage Publications, Newbury Park, California, 1992.
   The author summarizes the overlapping effects of various types of childhood trauma. The book is meant for medical professionals as well as mental health professionals.

3. Kluft RP. *Incest-Related Syndromes of Adult Psychopathology.* American Psychiatric Press, Washington, DC, 1990.
   This book is an excellent review of the effects of incest on personality development and psychosomatic disease.

SUBTOPIC 4

INTIMATE PARTNER VIOLENCE

TIMELINE (60 minutes)

5 min	Introduction/Ice Breaker
5 min	Review of Objectives/Format
5 min	Overview
25 min	Review of Case/Questions
15 min	Role-play
5 min	Additional Questions and Answers

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners, nurse practitioner trainees, nurse midwives, physician assistants and physician assistant trainees.

At the end of this discussion, participants should be able to:

1. Recognize warning signs of intimate partner violence.
2. Understand the dynamics of battering that keep partners involved in abusive relationships.
3. Recognize associated health behaviors and family risks often associated with intimate partner violence.
4. Understand the value of identification, referral, and reporting of intimate partner violence.
5. Know an effective method of asking about intimate partner violence in the health care setting.

SECTION 2 OVERVIEW

Thirty percent of women experience intimate partner violence during their lifetime. Between three and four thousand women and men are killed each year in this country during acts of domestic violence, and over 960,000 violent victimizations of women occur. Domestic violence often begins with trivial physical acts and escalates to cause serious injury and death. Young women, women who are separated, divorced or single, and low-income women are disproportionately victimized. Women of all races and ethnic backgrounds are about equally vulnerable to domestic violence.

Battering is often associated with other illnesses and problems, such as alcoholism, homelessness, drug addiction, and mental illness. Health care providers are often aware of the end result of domestic violence but fail to see the root causes of the problems they diagnose.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

Mary Keller is a 32–year–old married mother of three children who presents for treatment of a severe contusion to the forehead. The right side of her face is swollen and bruised. She has an old bruise over the sacrum. She is especially concerned about "blood in her eye," which on examination is a subconjunctival hemorrhage. Mrs. Keller reports that she was walking down icy steps when she slipped and fell forward, hitting the side of her face on the banister. At the time of the examination, she seems passive and dazed, answering questions with a flat affect and very soft voice.

A review of her medical record shows several requests for sedatives and sleeping pills in the past. In addition, she was treated for a concussion resulting from a fall in the bath tub.

Mrs. Keller is college educated and married to a successful lawyer.

1. In your clinical experience, are the frequency and severity of Mrs. Keller's injuries unusual? What might account for the number of unrelated accidents she has had?

2. What in the history and physical would suggest that Mrs. Keller is a victim of domestic violence?

3. Does the fact that her husband is a successful lawyer rule out the possibility that she is being battered?

4. Why do you think a woman who is being repeatedly battered would stay in a relationship with the batterer? How does this affect your response to her or your desire to help her? Does this make you feel angry or incredulous?

5. What other dysfunctional behaviors would you expect to find in a household where domestic violence occurs?

6. What is an effective way to ask patients about intimate partner violence?

7. When a health care practitioner suspects domestic violence is occurring, what are his/her options for treatment? Does he or she have a legal obligation to report the battering to the police? How can he or she get around the patient's denial that abuse is occurring?

8. What if the health care practitioner suspects that reporting domestic violence to a police agency will result in the battered woman's not coming back for care? What is the practitioner's ethical choice when reporting will mean the victims will refuse further care and become more isolated?

SECTION 4 SUGGESTED ANSWERS

1. *In your clinical experience, are the frequency and severity of Mrs. Keller's injuries unusual? What might account for the number of unrelated accidents she has had?*

   One must keep in mind that the number of times Mrs. Keller was treated by this health care provider may represent only a few of the accidents she has suffered. Battered women are likely to go to different facilities to avoid questions about their accidents.

2. *What in the history and physical would suggest that Mrs. Keller is a victim of domestic violence?*

   See Handout/Overhead 1 entitled, "Warning Signs of Intimate Partner Violence."

3. *Does the fact that her husband is a successful lawyer rule out the possibility that she is being battered?*

   No. Domestic violence occurs in all socioeconomic groups.

4. *Why do you think a woman who is being repeatedly battered would stay in a relationship with the batterer? How does this affect your response to her or your desire to help her? Does this make you feel angry or incredulous?*

   The reasons women stay in battering relationships are varied. They include:

   - Fear of injury or death to herself or her children—The highest risk of death in a battering relationship occurs immediately after a woman reports the abuse to outsiders and attempts to extricate herself from the relationship.
   - Fear of losing her children
   - Fear of economic ruin
   - Low self-esteem
   - Belief in traditional women's roles
   - Feelings of guilt or responsibility for the dysfunctional relationship
   - Belief that no one will believe her or help her if she discloses the abuse
   - Psychological minimization of the violence
   - Feelings that violence is normal, especially if she grew up in an abusive home

5. *What other dysfunctional behaviors would you expect to find in a household where domestic violence occurs?*

See Handout/Overhead 3 entitled, "Intimate Partner Violence—Associated Behaviors and Risks." Also, child abuse is a common occurrence in households where intimate partner violence occurs. One study showed that the greater the amount of violence that occurred against a spouse, the greater the probability that children in the family would be physically abused. The probability of child abuse by a violent husband increased from 5% with one act of marital violence to near certainty with 50 or more acts. Assessing the safety of children in households where intimate partner violence occurs is critically important.

6. *What is an effective way to ask patients about intimate partner violence?*

A recent study has shown that using a brief, three-question partner violence screen provided a sensitive and specific tool for identifying intimate partner violence. These three questions can be asked verbally or as part of a written health screening.

See Handout/Overhead 2 entitled, "Screening Questions for Intimate Partner Violence."

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?

2. Do you feel safe in your current relationship?

3. Is there a partner from a previous relationship who is making you feel unsafe now?

7. *When a health care practitioner suspects domestic violence is occurring, what are his/her options for treatment? Does he or she have a legal obligation to report the battering to the police? How can he or she get around the patient's denial that abuse is occurring?*

Many, but not all, states have laws requiring the reporting of crimes when injury victims are seen for medical care. The advisability of these laws is debated. Some victims' advocates maintain that mandatory reporting takes control away from the victim, particularly when intervention by police may lead to more dangerous escalation of the violence toward the victims. Others say that reporting takes the responsibility for their safety away from the victim and places it where it belongs, with law enforcement. They see this as an effective way to protect women who might not otherwise be capable of protecting themselves. Health care practitioners should be aware of the laws regarding reporting of domestic violence in their states.

When domestic violence is suspected, the health care practitioner can also do the following:

- Assess the risk to the victim and her children. Report suspected child abuse if the children are in danger.

- Confront the victim. Share concerns about domestic violence. Reassure her that others have faced similar situations and managed to successfully recover.
- Inform the victim about resources available in your community, including shelters, support groups, legal services and counseling services.
- Maintain a relationship with the patient. Leave the door open for future interventions.
- Most of all, be nonjudgmental. Accept and respect the woman's assessment of her own situation.
- Never try to intervene with or confront the batterer. This could put the victim at increased risk, as well as create a risk for the health care practitioner.
- Thoroughly document findings and injuries, and include diagrams and pictures.

7. *What if the health care practitioner suspects that reporting domestic violence to a police agency will result in the battered woman's not coming back for care? What is the practitioner's ethical choice when reporting will mean the victim will refuse further care and become more isolated?*

   There is no right answer to this question. Different participants will probably have different views. However, the American Medical Association has stated that physicians have an ethical duty to diagnose and treat domestic violence, and that that obligation goes beyond treatment of the physical injuries alone.

SECTION 5 ROLE PLAY

Organize a role play that includes the following characters:

- Mrs. Keller, a passive, non-communicative victim of domestic violence
- Mr. Keller, her outwardly successful husband who is angry and controlling
- The family physician working with the Kellers

The setting: The physician, concerned about Mrs. Keller's health, has asked her to come to the office to discuss her frequent injuries. During the session, Mrs. Keller denies domestic violence. The physician talks with her about alternatives to battering.

An alternative setting: Mr. and Mrs. Keller come to the office because Mr. Keller is suspicious that Mrs. Keller has talked with the doctor about abuse. Mr. Keller found literature the physician had given Mrs. Keller about battered women's shelters and services. Mr. Keller is angry about the accusations. During the interview he threatens the physician with a law suit for interfering in the Kellers' family life. Role play the physician's response in assuring Mrs. Keller's safety after this confrontation.

SECTION 6 SUGGESTED READING

1. *Family Violence: An Overview*. US Department of Health and Human Services, Office of Human Development Services, Washington, DC, 1991.
   An excellent, brief review of the relationship between spouse abuse, child abuse and other types of family violence.

2. Salber PR, and Taliaferro E. *Physician's Guide to Domestic Violence: How to Ask the Right Question and Recognize Abuse*. Volcano Press, Volcano, CA, 1995.
   This book is a 'primer' for primary care and specialty physicians caring for women.

3. American Medical Association: *Diagnostic and Treatment Guidelines on Domestic Violence.* American Medical Association, Chicago, IL, 1992.
   The AMA's guidelines of domestic violence can be ordered from the AMA's website,

4. Straus MA, and Gelles RJ. *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families.* Transaction Press, New Brunswick, NJ, 1990.
   A national survey of the extent, patterns, and causes of violence in American families.

SECTION 7 AUDIO-VISUAL RESOURCES

1. **Seminar Series on Domestic Violence.** A videotape and self-teaching CD-ROM designed for health care professionals, the set covers diagnosis of domestic violence, methods of communication with patients about domestic violence, and risk assessment methods. Interactive cases are presented on the CD-ROM disk. The videotape is available for $25, the CD-ROM is available for $100, and a slide set on domestic violence is available for $100.

Author/Developer: Elaine J. Alpert, MD, MPH and Cheryl L. Albright, PhD, MPH

Contact: Published by the Massachusetts Medical Society Dept. of Public Health, 1440 Main Street, Waltham, MA 02451-1600. Phone: 781-893-4610, ext. 1015.

SECTION 8 HANDOUTS/OVERHEADS (ATTACHED)

Warning Signs of Domestic Violence

Repeated injuries, especially to face, neck, throat, chest, abdomen and genitals

Substantial delay between injury and treatment

Multiple injuries in various stages of healing

Extent and type of injury inconsistent with history

Psychosomatic/emotional complaints

Repeated emergency room use

Source: Duffy SJ. Domestic Violence and the pediatric Practitioner. *Infants & Children.* 1997;4:1–5.

HANDOUT/OVERHEAD 1

Screening Questions for Intimate Partner Violence

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?

2. Do you feel safe in your current relationship?

3. Is there a partner from a previous relationship who is making you feel unsafe now?

HANDOUT/OVERHEAD 2

Intimate Partner Violence—Associated Behaviors and Risks

Drug/alcohol abuse

Child abuse

Sexual assault

Emotional abuse

Elder abuse

HANDOUT/OVERHEAD 3

SUBTOPIC 5

A COMMUNITY-ORIENTED PRIMARY CARE APPROACH TO DOMESTIC VIOLENCE

Developed by Mary Lou C. Ashur, M.D., Center for Community Responsive Care, Carney Hospital, Boston, Massachusetts

TIMELINE (60 minutes)

5 min	Introduction/Ice Breaker
5 min	Review of Objectives/Format
5 min	Overview
45 min	Review of Case/Questions

SECTION 1 LEARNING OBJECTIVES

Target Group: Physicians in training and in practice, nurse practitioners, nurse practitioner trainees, nurse midwives, physician assistants and physician assistant trainees.

At the end of this discussion, participants should be able to:

1. Define health in a way that includes medical, psychological, and social well being.

2. Develop a list of medical caregivers, community social service providers, and governmental agencies involved in responding to issues of domestic violence.

3. Empower the practitioner to act as a primary care/public health catalyst in organizing a community-oriented primary care response.

4. Optional: Understand primary prevention, secondary prevention, and tertiary prevention.

SECTION 2 OVERVIEW

As health practitioners endeavor to cure illness and repair injury, victims of domestic violence suffer amidst us. Once unrecognized as a cause of both physical injuries and mental anguish, domestic violence now defines a syndrome with medical, psychological, and public health implications. The problem affects all segments of the population, not just women or disadvantaged groups. The need for an integrated community response is being simultaneously articulated by medical colleagues, legal minds, law enforcement officials, and the people we serve.

This subtopic offers the opportunity to conceptualize and develop a community-based action plan. While it does not focus on how a provider must care for an individual patient, it offers a four-step process for community organization around this issue. It describes how the health care provider can form an alliance with the victim of domestic violence to decrease her isolation and increase her safety. It also discusses how the provider can work with the community to break the conspiracy of silence surrounding this issue.

NOTE TO THE LEADER: Discussion of child abuse and intimate violence may provoke emotional responses from some participants during or after formal sessions. Think about how you will create a safe environment for participants who might choose to reveal personal experience. You may want to state that you are available for follow-up conversations or identify community resources.

In addition, using a coalition approach to address controversial issues is not always a smooth, straightforward process. This case study does not focus on group problems that may arise, but the facilitator might want to interject some difficulties the coalition may encounter in working together or developing an intervention.

Finally, the use of Native Americans here is just one example of a population group that is affected. The facilitator should feel free to adapt the case and the intervention to fit the needs of other cultural groups and the interests of the audience.

SECTION 3 CASE STUDY/DISCUSSION QUESTIONS

For the second time this month and the fourth time this year, the woman presented to the Indian Health Service (IHS) emergency room for medical care. She had abrasions on her forehead, shoulders, and legs. Vicryl sutures, now three weeks old, stretched across her edematous scalp. She had been raped and beaten with a beer bottle by the father of her oldest child.

Last week she and her children made the four-hour journey back from Phoenix to the reservation; the battered women's shelter in Phoenix closed when funding ran out. Although there was a longstanding warrant for his arrest, her batterer had not been picked up.

Several cases like this have become apparent to staff members of the IHS emergency room. The medical provider decided to invite people from multiple disciplines together to examine domestic violence on the reservation. The coalition met for a series of five "cluster meetings" designed to evaluate the problem and develop an intervention.

1. Given the World Health Organization (WHO) definition of health as physical, mental, and social well being, not merely the absence of disease or infirmity, what are this woman's health problems?

2. What elements of the social, medical, and legal system permitted this violence to recur?

3. Who should be on the community-based coalition organized to address domestic violence in this tribal community?

4. The agenda for the first cluster committee meeting was to define and characterize the community and its resources. What parameters would you like to know?

5. The second cluster meeting addressed the issue of domestic violence. How do you define domestic violence? How can you describe the problem for this community?

6. The agenda of the third cluster meeting was to design prevention strategies for domestic violence. What interventions might the coalition propose?

7. At the fourth cluster meeting the coalition prioritized goals and chose immediate and long-term program plans. How would you, as a member of the coalition, answer these questions: What do we want to achieve? How do we know when we get there? Is there anything preventing us from getting there?

8. The final cluster meeting focused on determining how this work could be institutionalized. What are some possible answers?

9. Optional: There are three types of prevention—primary, secondary, and tertiary. Primary

prevents a medical problem from occurring. Secondary involves detection of a medical problem. Tertiary prevention is treatment of a medical condition to lessen morbidity or prevent spread of disease. Can you give an example of each type of prevention?

SECTION 4 SUGGESTED ANSWERS

1. *Given the World Health Organization's definition of health as physical, mental and social well being, not merely the absence of disease or infirmity, what are this woman's health problems?*

   A problem list may include the following:

   - Medical: The woman suffers from lacerations and contusions. Because she has been raped, she is also at risk for pregnancy, venereal diseases and pelvic injuries.
   - Psychological: She may suffer confusion, anxiety, isolation, depression and other psychiatric disturbances.
   - Social: A mother with responsibility for her children and possibly her extended family, this woman needs a safe place to go, as well as food and housing. She needs money, education, and employment. Finally, she needs psychiatric and social support.

2. *What elements of the social, medical, and legal system permitted this violence to recur?*

   Think about fragmentation in the medical delivery system and society's safety nets. For example:

   - The shelter in Phoenix was closed for lack of funding,
   - Police did not arrest her batterer.
   - There was no medical follow up accessible.
   - The woman did not have access to consistent professional psychiatric or social services.

3. *Who should be on the community-based coalition organized to address domestic violence in this tribal community?*

   The interdisciplinary coalition might include:

   - Physicians and other health care providers
   - Nurses from ambulatory care and emergency departments
   - Hospital administrators
   - Hospital psychiatrists
   - Hospital social workers
   - Public health nurses
   - Tribal guidance center staff
   - Primary and secondary school principals and interested teachers

- Clergy
- Chief
- Members of tribal council
- Major employers, such as chairman of the board of the local ski area
- Newspaper reporters
- Interested residents
- Victims of domestic violence in recovery

4. *The agenda for the first cluster committee meeting was to define and characterize the community and its resources. What parameters would you like to know?*

   Think about how to define and characterize the community and what data sources may be used. Pertinent questions include:

   - How many people are on the reservation?
   - What is the age structure of the population?
   - What is the family structure of the population?
   - What is the history of the tribe?
   - How are government, law enforcement and legal services organized?
   - What health services are available?
   - What social services are available?
   - What is the socioeconomic status of the tribe?

   Data sources may include:

   - Indian Health Service statistics
   - Tribal council publications and records
   - Bureau of Indian Affairs data
   - Interviews with leaders and community members on the reservation

   (See Handout/Overhead 1 entitled "Parameters to Define and Characterize This Indian Community" for specific responses to some of these questions.)

5. *The second cluster meeting addressed the issue of domestic violence. How do you define domestic violence? How can you describe the problem for this community?*

   - Develop your own definition of domestic violence; it may include child abuse, partner abuse, and elder abuse. Then focus this definition into a working definition for the intervention. (See Handout/Overhead 2 entitled "Definition of Domestic Violence and Parameters of Problem for the Community" for example.)

   - Determine if the problem is measured directly, or what statistics may estimate the

problem for the community. You may use hospital emergency room, out-patient or in-patient diagnosis date, hospital billing information, state vital statistics, police or FBI crime data, etc. (See handout entitled "Definition of Domestic Violence and Parameters of Problem for the Community" for specific data.)

6. *The agenda of the third cluster meeting was to design prevention strategies for domestic violence. What interventions might the coalition propose?*

The coalition can use a brainstorming session to develop a matrix of possible interventions by the community. See Handout/Overhead 3 entitled "Matrix for Prevention of Conjugal Violence and Injuries for Indian Community."

7. *At the fourth cluster meeting, the coalition prioritized goals and chose immediate and long-term program plans. How would you, as a member of the coalition, answer these questions: What do we want to achieve? How do we know when we get there? Is there anything preventing us from getting there?*

The coalition may set a goal of identifying domestic violence in the community and reducing its incidence by 50% over the next two years with prevention programs.

As a short-term objective, the coalition may want to develop an immediate plan to help victims in crisis. The coalition could start a 24-hour telephone line where members of the coalition could be reached by the hospital operator to counsel victims, perpetrators, police, or others in need of assistance.

Long-term objectives may be prioritized and could include:

- Education of health caregivers, police, and community residents on domestic violence
- Data collection by hospital and law enforcement personnel
- Development of a safe house on the reservation
- Programs directed at youth and families to prevent violence
- Coordination of services to victims and their families

Small groups can develop timelines and identify community resources to meet these goals. Program evaluations should be collected for each intervention.

8. *The final cluster meeting focused on determining how this work could be institutionalized. What are some possible answers?*

The coordination of efforts by coalition members of the community provides a forum to address this and other health issues. The coalition can plan monthly meetings for one year,

followed by quarterly meetings in which it will function as a health advisory board.

The IHS hospital's emergency room and ambulatory care protocols can become part of hospital policy and a model for other institutions. Teachings on domestic violence can become part of orientations and annual in-service training.

The tribal council can appoint an office of social services to coordinate these and other community efforts.

9. *Optional: There are three types of prevention—primary, secondary, and tertiary. Primary prevents a medical problem from occurring. Secondary involves detection of a medical problem. Tertiary prevention is treatment of a medical condition to lessen morbidity or prevent spread of disease. Can you give an example of each type of prevention?*

- Primary prevention: Examples include smoking education programs in high school and the "Friends don't let friends drive drunk" campaign.
- Secondary prevention: Examples include stool guaiac for detection of intestinal neoplasms, and screening mammography.
- Tertiary prevention: Examples include antibiotic treatment of patients with gonorrhea and screening and treatment of sexual contacts; and surgical excision, chemotherapy, or radiation therapy of a lung tumor.

SECTION 5 SUGGESTED EXERCISE

As a group, discuss how this case study might look if there was a different cultural group involved. Using a cultural group with which the participants are familiar, identify possible differences in the situation, family and community response, and appropriate community leaders to serve on the coalition. Also, discuss barriers you might encounter working with a cultural group different from your own.

SECTION 6 SUGGESTED READING

1. Domestic Violence and the Internists' Response: Advocacy or Apathy? Editorial. *Journal of General Internal Medicine*, Vol. 5 (Jan/Feb), 1990, 89.
   Brief article on physicians' traditional reluctance to intervene for domestic violence patients.

2. Family and other Intimate Assaults—Atlanta 1984. *Morbidity and Mortality Weekly Report*, Vol. 39, No. 31, August 10, 1990, 525.
   Statistical analysis of intimate violence for a given community in 1984.

3. Institute of Medicine. *The Future of Public Health.* National Academy Press, Washington, D.C., 1988.
   An important resource for any public health practitioner of primary care, this book discusses strides in public health. It also challenges the government and providers to develop a public health mission for the future.

4. Unintentional Injuries. In *Healthy People 2000: Model Standards,* 3rd edition, Washington D.C., American Public Health Association, 1991, 111.
   This chapter guides communities in self-assessment of health status and health planning.

5. Trends in Indian Health 1991. Indian Health Service, U.S. Department of Health and Human Services, 1991.
   Statistical information on selected health statistics for Native Americans.

6. Widon CS. The Cycle of Violence. *Science*, Vol. 244, 14 April 1989, 160.
   This article details the fundamental theory of perpetration of intimate violence.

SECTION 7 HANDOUTS/OVERHEADS (ATTACHED)

Parameters to Define and Characterize this Indian Community

Fifteen thousand tribal members live on a large tract of the Arizona desert and mountains. In the world's largest stand of Ponderosa pine, this land had been part of the traditional summer home of the formerly nomadic tribe of hunters and gatherers. Today's tribe is a forced amalgamation of two separate bands. The bands were sometimes adversaries and sometimes allies against the intruding Caucasians. In this tribe's tradition, men were warriors and women were responsible for the home and family. Forty percent of the tribe is under 18; 40% of the tribe is 18–45 years old. The family structure is matriarchal, with husbands joining the wives' clan.

The tribal council of elected officials is 90% male. The tribal council governs the reservation; the police force reports to the tribal council. Education has been the responsibility of the Bureau of Indian Affairs. One school has been taken over by the tribe.

The Indian Health Service (IHS) of the U.S. Public Health Service runs the 50-bed hospital and two ambulatory care centers. All people of Native American ancestry have access to the health resources of the IHS and to mental health services at the tribal-run Tribal Guidance Center. IHS physicians, nurses, and other health care providers have been appreciated by the community; in fact, there are an estimated 65,000 patient contacts per year. Traditional medicine is also practiced on the reservation.

Poverty is the norm for this community. There is seasonal work on logging or fire crews, at the tribal ski resort and in the tribe's small cattle herd. The tribal council has spent most of its meetings this year discussing water rights—determining how to tax growing urban communities who depend on water that flows from tribal mountains.

HANDOUT/OVERHEAD 1

Definition of Domestic Violence and Parameters of Problem for the Community

Domestic violence is characterized by a pattern of controlling behaviors that include repeated sexual assault, psychological battering, physical abuse, and injury. It also involves social isolation and intimidation. The batterer may control many components of the victim's life, such as access to shelter, food, transportation, money, health care, employment, family, and friends.

While this cluster committee chose to focus on abuse of women by male partners, domestic violence may also include abuse of children, elders, or same-sex partners.

The coalition learned that the hospital did not collect statistics on domestic violence. Among statistics they did collect, local trends mirrored national health statistics.

- Injuries and poisonings were the fourth leading cause for hospitalization among Native American women, behind obstetrical care and respiratory and digestive ailments.

- Non-vehicular accidental deaths for Native American women ages 25–34 were 39.5/100,000, compared with 11.5/100,000 for all U.S. women (1987).

- Accidents were the leading cause of death among female Native Americans ages 25–44, at 40/100,000 (1987).

- Suicidal mortality among Native Americans ages 24–34 was 8.3/100,000, and among ages 35–44 it was 9.3/100,00 in 1987. This is compared with completed suicide rates for all U.S. women ages 24–34 of 5.9/100,000 and for women ages 35–44 of 7.2/100,000 (1987).

Somewhere buried in these statistics is the toll of domestic violence on women. Battered women may account for 25% of women who attempt suicide. According to various studies, domestic violence may account for 22–35% of women seeking care in emergency rooms, the majority of whom are seen by non-trauma services.

(U.S. Department of Health and Human Services, "Trends in Indian Health, 1991. Indian Health Service." 1991.)

HANDOUT/OVERHEAD 2

Matrix for Prevention of Conjugal Violence and Injuries for Indian Community

	Pre-event	Event	Post-Event
Woman	Lessen feeling of entrapment Eliminate gender identity conflict Eliminate marital stress Sense of empowerment Self-defense training help Realistic perception of relationship	Recognize cycle of violence Add neutral adult buffer Leave situation Eliminate victim reticence to seek	Shelters, safe houses Prepared emergency room and hospital personnel Therapeutic programs, inpatient and outpatient Victim support groups Family therapy
Perpetrator	Confront history of family violence Eliminate drop-out rate/ poor education status, unemployment Lessen familial patriarchy Develop social opportunities for man to identify himself as traditional, strong Apache warrior	Recognize and take responsibility for actions Leave situation	Timely arrest and jailing of perpetrator Appropriate court judgment Imprisonment Treatment programs AAA—"Apache Abuser Anonymous" Family therapy Treat alcoholism
Substances			
Environment	Tradition/social learning Folk stories Eliminate inequality Eliminate poverty and crowding Eliminate alcohol as an enabler Eliminate approval of marital violence	"Help" telephone lines Rapid police	Transportation and access to shelters Prosecution and response punishment of perpetrators Assistance to victim and her children Family support programs

	Pre-event	Event	Post-Event
Substances Environment (cont.)	School-based education to build self-esteem and explain violence Church-based education Tribal council education and program development Enforce and develop laws		
Medical/ Community Team	Medical/nursing/mental health education on identification and and response Work with tribal council to coordinate community education Talk to school and church groups Prevent social disintegration Social events, fairs	Acute medical care Identify injury as related to abuse, address it and report it Victim emotional support	Spouse abuse abatement program Document injuries and act as a witness in court Traditional human service interventions

HANDOUT/OVERHEAD 3